



**STATE OF ILLINOIS  
DEPARTMENT OF HUMAN SERVICES  
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

<b>Student's Name</b>			<b>Birth Date</b>			<b>Sex</b>	<b>School</b>			<b>Grade Level /ID#</b>				
Last	First		Middle		Month/Day/ Year									

<b>Address</b>				<b>Parent/Guardian</b>				<b>Telephone #</b>				<b>Work</b>				
Street	City			ZIP code							Home					

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		Comments
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

**Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.**

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b> (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	<b>Title</b>	<b>Date</b>
<b>Signature</b> (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	<b>Title</b>	<b>Date</b>

**ALTERNATIVE PROOF OF IMMUNITY**

1. **Clinical diagnosis is acceptable if verified by physician.** \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**  
 Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title	Date
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3. **Laboratory confirmation (check one)**  Measles  Mumps  Rubella  Hepatitis B  Varicella  
 Lab Results Date MO DA YR (Attach copy of lab report, if available.)

**VISION AND HEARING SCREENING DATA**

Pre-school – annually beginning at age 3; School age – during school year at required grade levels														
Date														
Age/Grade														
	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision														
Hearing														

**Code:**  
 P = Pass  
 F = Fail  
 U = Unable to test  
 R = Referred  
 G/C = Glasses/Contacts

<b>Student's Name</b>	<b>Birth Date</b>	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
Last First Middle	Month/Day/ Year			

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes No
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes No
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes* No
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes* No
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes No
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes No
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes No
Dizziness or chest pain with exercise?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other	
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Other concerns?	
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.	
Bone/Joint problem/injury/scoliosis?	Yes	No		<b>Parent/Guardian Signature</b>	<b>Date</b>

**Entire section below to be completed by MD/DO/APN/PA (\*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)**

<b>PHYSICAL EXAMINATION REQUIREMENTS</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE*</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> <b>Blood Test Result</b> (Blood test required in Chicago and other high risk zip codes.)				
<b>TB SKIN TEST</b> Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <b>Date Read</b> / / <b>Result</b> <b>mm</b>				
<b>LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES</b>	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>
Hemoglobin * or Hematocrit *		Sickle Cell * (as indicated)		
Urinalysis		Other		
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	
<b>NEEDS/MODIFICATIONS</b> required in the school setting			<b>DIETARY</b> Needs/Restrictions	
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup				
<b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal				
<b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.				
<b>On the basis of the examination on this day, I approve this child's participation in</b> (If No or Modified, please attach explanation.) <b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>				
Physician/Advanced Practice Nurse/Physician Assistant performing examination				
<b>Print Name</b>	<b>Signature</b>			<b>Date</b>
<b>Address</b>	<b>Phone</b>			

(Complete both sides)

**LOCKPORT TOWNSHIP HIGH SCHOOL**  
**DISTRICT 205**  
**ADMINISTERING MEDICATION TO STUDENTS**

**Section I**

**Prescription Medication**

Medication required by a student shall generally not be administered at school by a District employee. This policy includes even common and widely used over-the-counter preparations.

However, students recovering from temporary illness or students on permanent medication who require medication during the school day may bring medication to school following these guidelines:

1. A written statement from the student's physician, indicating the necessity for the medication along with the medication name and dosage, administration route and /or other direction, licensed prescriber's name, pharmacy name, address and telephone number.
2. A written request for permission to administer the medication along with a written release of liability from the parent(s)/guardian(s) shall be required.
3. Medication shall be brought to school in appropriately labeled containers. The name of the student and the names and phone numbers of the physician and pharmacy shall be indicated on the containers.

Prescription medication shall be administered by the school nurse or other designated personnel.

All prescription medication with the exception of inhalers will kept in a locked drawer or cabinet.

**Section II**

**Non-prescription Medication**

District 205 follows the state guidelines for medication administration. This means that students are responsible for their own over-the-counter medication such as Tylenol, Midol, aspirin, etc., as long as they have a written medication authorization from their parent or guardian on file in the nurse's office for all non-prescription medication that they bring to school. No non-prescription medication will be supplied at any time to any student by District 205 employees. Non-prescription over-the-counter medication must be taken in the nurse's office under adult supervision. All medication should be in its original container and labeled with the student's name. No loose pills or capsules are to be carried by the student in school. **Under no circumstances** are students to share their medication with one another.

Each student must take responsibility for understanding the medication he/she is taking. He/she should be able to verbally articulate the medication name and dosage, the route taken, why it is needed and its possible side effects as well as how many hours are needed between each dose.

No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures.

In all cases the school retains the discretion to reject a request for administering medication.

**LOCKPORT TOWNSHIP HIGH SCHOOL DISTRICT 205**

**PRESCRIPTION MEDICATION AUTHORIZATION FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Orders: (to be filled out by the **ATTENDING DOCTOR**—PLEASE PRINT)

\_\_\_\_\_  
Name of Medication Dosage

\_\_\_\_\_  
Time Route

\_\_\_\_\_  
Prescription Date Expected Discontinuation Date

\_\_\_\_\_  
Reason for prescribing medication during school hours

\_\_\_\_\_  
Time interval for re-evaluation

\_\_\_\_\_  
Possible side effects of medication:

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent Authorization**

I hereby authorize \_\_\_\_\_ to take the medication as prescribed above. Prescription medication, except for inhalers, will be kept in the nurse's office. All prescription drugs shall be prescribed by an Illinois licensed physician or dentist. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against School District 205, its employees and agents, arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action, or injuries incurred or resulting from the administration or attempts at administration of said medication, including the self-administration of inhalers and M.D. ordered non-prescription medications.

\_\_\_\_\_  
Parent/Guardian Signature Home/Work/Cell Phone Numbers

\_\_\_\_\_  
Address

\_\_\_\_\_  
Emergency Number

